

Section 5 Submitting Claims to Medicaid

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies, and do not highlight the claim or any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. EDS uses optical scanning technology to store an electronic image of the claim, and the scanners cannot detect carbon copies, photocopies, or any color of ink other than black. Carbon copies, photocopies, and claims containing a color of ink other than black, including highlighting, will not be processed and will be returned to the provider.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File** form. (Providers who file claims electronically are not required to complete this form. Refer to **Submitting Claims Electronically**, below.) Please note that out-of-state providers (providers more than 40 miles from the North Carolina border) are required to have a signature on the claim.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number—such as home health agencies, hospitals, and facilities (including adult care)—should have the certification signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available in **Appendix G-21** or on the DMA Web site at <http://www.ncdhhs.gov/dma/forms.html>. Fax or mail completed certifications two weeks in advance of submitting claims without a signature.

Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Commerce Services (ECS). EDS will process claims submitted through file transfer protocol and asynchronous dial-up.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to **Section 10, Electronic Commerce Services**, for additional information about electronic billing and ECS services.

Billing on the CMS-1500/ CMS-1500 (08/05) Claim Form

Listed below are some of the provider types who bill Medicaid using the CMS-1500 claim form:

- Ambulatory surgery center*
- Audiology or speech pathology, physical therapy, occupational therapy, and psychological services, case management services (DSS)
- Certified registered nurse anesthetist*
- Chiropractor*
- Community Alternatives Program
- Durable medical equipment*
- Federally qualified health center*
- Free standing birthing center*
- Head Start
- Health department
- Hearing aid dealer
- HIV case management
- Home infusion therapy
- Independent diagnostic testing facility*
- Independent laboratory*
- Independent mental health provider
- Independent practitioner
- Local education agency
- Mental health center
- Nurse midwife*
- Nurse practitioner*
- Optical supply dealer
- Optometrist*
- Orthotics and prosthetics*
- Personal care services
- Physician*
- Planned Parenthood (non-medical doctor)*
- Podiatrist*
- Portable X-ray
- Private duty nursing services
- Residential evaluation services
- Rural health clinic**

*Some provider types are mandated to bill Medicaid using modifiers. Please refer to the **April 1999 Special Bulletin II, Modifiers**, for Medicaid modifier usage guidelines.

**Modifier usage is subject to non-core services only.

Medicaid special bulletins are available on DMA's Web site at <http://www.ncdhhs.gov/dma/bulletin.htm>.

Note: Before billing, please refer to program-specific instructions for completing a claim. These are available on DMA's Web site at: <http://www.ncdhhs.gov/dma/mp/mpindex.htm>. Please note claim form information in **Appendix G**.

Billing on the UB-92/UB-04 Claim Form

Listed below are some of the provider types who bill on the UB-92/UB-04 claim form:

- Adult care home
- Ambulance
- Area mental health center
- Dialysis facility
- Home health agency
- Hospice
- Hospital
- Intermediate care facility for mental retardation
- Nursing facility
- Psychiatric residential treatment facility
- Residential child care facility (Level II, III, and IV)

Billing on the ADA 2002/ADA 2006 Claim Form

Listed below are some of the provider types who bill on the American Dental Association (ADA) claim form:

- Dentist
- Federally qualified health center (dental services only)
- Health department dental clinic (dental services only)
- Rural health clinic (dental services only)

Refer to Clinical Coverage Policy #4, *Dental Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/dental.htm>, for instructions on completing the ADA claim form.

New Claim Form Instructions

The following is reprint of a North Carolina Medicaid Special Bulletin issued in December 2006 and revised in June 2007.

The CMS-1500 (12/90), the UB-92 and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS-1500 (08/05), the UB-04 and the ADA 2006 claim forms, respectively. Medicaid will begin accepting the claim forms effective with the dates shown below. Paper claims submitted on the old forms will not be processed after the date shown in the last column and will be returned to the provider. The intent of this bulletin is to address claim form changes only. **NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA.** For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

Claim form	Medicaid will accept the new paper form on:	Claims must be submitted on the new format no later than:
CMS-1500 (08/05)	Jan. 1, 2007	July 1, 2007
UB-04	March 1, 2007	Final date to be announced
ADA 2006	March 1, 2007	November 15, 2007

The revised paper claim forms coincide with the implementation of the National Provider Identifier (NPI) as the standard unique health identifier for providers (see <http://www.ncdhhs.gov/dma/> for more information). N.C. Medicaid will allow a transition period to convert from the old paper claim forms to the new claim forms. Each form contains specific changes that will affect Medicaid claims processing, and specific time periods within which particular information must be submitted. Explanation of Benefits (EOB) verbiage will be changing to reflect the use of the revised paper claim formats. Please carefully review the Medicaid-related guidelines in this Bulletin.

SECTION 6 DEFINITIONS

Atypical Provider: Provider who does not render health care services and is not eligible for an NPI. Example: a contractor who builds a wheelchair ramp on a recipient's home.

CA PCP: Carolina ACCESS Primary Care Physician

National Provider Identifier (NPI): New identifier issued through the National Plan and Provider Enumeration System (NPPES) developed by CMS. NPI will replace all Medicaid provider numbers currently used for billing purposes.

Qualifier: Identifies whether the number to the immediate right on the claim represents a Medicaid provider number (1D for CMS 1500 and G2 for UB04) or a taxonomy code (ZZ for CMS 1500 and B3 for UB04).

Taxonomy number: Code identifying a provider type and specialty

SECTION 7 OVERVIEW OF CLAIM FORM CHANGES

Pending NPI implementation, continue to bill using your Medicaid Provider Number.

The following table provides a brief overview of changes for all claim forms. These changes will affect claims processing. Explanations of these changes and definitions of terms will be provided in the following pages.

UB-04	CMS-1500	ADA
Carolina ACCESS NPI or Medicaid Provider Number	Carolina ACCESS NPI or Medicaid Provider Number	NPI—Billing and Attending
No Signature field	NPI—Billing, Attending or Referring	Taxonomy—Billing and Attending
NPI—Billing, Attending and Referring	Qualifier 1D and ZZ	ZIP + 4 Code for Service Facility Location and Billing Location
Payer Code	Taxonomy—Billing, Attending	Medicaid Billing Provider Number for Prior Approval Purposes only.
Qualifier B3 and G2	ZIP + 4 Code for Service Facility Location and Billing Location	
Taxonomy—Billing		
Value Codes		

ZIP + 4 Code for Service Facility Location and Billing Location		
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SECTION 8 CLAIM FORM INSTRUCTIONS

Because providers are allowed to submit both Medicaid provider information *and* NPI information on claims during the transition period, there are two claim examples for each claim form: one for revised claim transition and one for NPI implementation. Refer to NPI publications for NPI implementation dates.

CMS-1500 (08/05) Changes Effective Jan. 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at www.nucc.org. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

- Field 17a: Enter either the referring provider (the Medicaid provider number) or CA PCP provider number for claims requiring CA authorization (the Medicaid provider number) or the CA ACCESS override number assigned by EDS in the shaded field 17a. Qualifier 1D must precede either of these numbers in the delimited block immediately to the right of the field identifier “17a.”
- Field 17b: The referring provider’s NPI or CA PCP NPI for claims requiring CA authorization may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI in addition to the Medicaid provider number.
- Fields 24i and 24j, Attending Provider Number: If the procedure requires an attending provider number, the attending number must be entered.
 - Field 24j NPI (lower portion of the field): The attending provider’s NPI may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI.
 - Fields 24i and 24j (upper shaded portion of the field): Enter qualifier 1D in field 24i and the attending provider’s Medicaid number in 24j. After NPI implementation enter the taxonomy code in 24j with qualifier ZZ in 24i (During transition, taxonomy is not required).
- Field 32, Service Facility Location: Address where service was rendered, including ZIP + 4 Code.

- Field 33, Billing Provider Information: Provider address must include ZIP + 4 Code.
- Field 33a: Enter the Medicaid billing provider's NPI. N.C. Medicaid requests that providers immediately start submitting the NPI
- Field 33b: Enter the Medicaid number, preceded by qualifier 1D. (This field is not specifically delimited.) It is not necessary to enter a space between qualifier 1D and the Medicaid number. After NPI implementation the taxonomy code with qualifier ZZ should be entered (During transition, taxonomy is not required).

CMS-1500 (08/05) Form Instructions for Field Changes Effective Jan. 1, 2007

Instructions for completing the standard CMS-1500 claim form as it relates to the claim form field changes are listed below. Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUCC. The NUCC instruction manual can be found at www.nucc.org. Refer to NPI publications for NPI implementation dates. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

Block	Block Name	Explanation
17.	Name of Referring Provider or Other Source	Use for referring provider's name.
17a.	Other ID Number	Use for CA override or Medicaid provider number (for CA authorization) with qualifier 1D, or taxonomy code with qualifier ZZ. During transition, taxonomy is not required.
17b.	NPI	Use for referring provider NPI or Carolina ACCESS PCP's NPI for CA authorization.
19.	Reserved for Local Use	Please be aware that Medicaid will no longer use block 19 for Carolina ACCESS.
24I. (upper shaded portion)	Qualifier	Enter qualifier 1D if entering Medicaid provider number or ZZ if entering taxonomy. During transition, taxonomy is not required.
24J. (upper shaded portion)	Rendering Provider ID Number	Enter Medicaid attending provider number or taxonomy. During transition, taxonomy is not required.
24J. (lower unshaded portion)	Rendering provider ID number	Enter attending provider NPI.
32.	Service Facility Location Information	Enter the ZIP + 4 Code.
33.	Billing Provider Info and Phone Number	Enter the billing provider's name, street address including ZIP + 4 Code and phone number.
33a.	NPI	Enter the billing provider's NPI.
33b.	Other ID Number	Enter the Medicaid provider number with 1D qualifier or taxonomy with ZZ qualifier. During transition, taxonomy is not required.

Note: Quick Reference Guides for Carolina ACCESS Provider on pages 17-21

1500

CMS 1500 Example Effective January 1, 2007:**Revised Claim through NPI Implementation Date (to be announced)****HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BULK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										CITY STATE									
ZIP CODE TELEPHONE (Include Area Code)										ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
14. DATE OF CURRENT SERVICE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LOCALITY <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. NPI for CA PCP for CA authorizations, referring provider or CA override number (if applicable).										22. MEDICAID ATTENDING PROVIDER NUMBER									
23. PRIOR AUTHORIZATION										24. J. RENDERING PROVIDER ID. #									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										24. B. PLACE OF SERVICE									
24. C. EMG										24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
24. E. DIAGNOSIS POINTER										24. F. \$ CHARGES									
24. G. DAYS OR UNITS										24. H. FSDT Family Plan									
24. I. ID. QUAL.										24. J. RENDERING PROVIDER ID. #									
25. FEDERAL TAX I.D. NUMBER										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. BILLING PROVIDER INFO & PHONE #									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. NPI									
33. BILLING PROVIDER information. Must include ZIP + 4 Code.										33a: NPI for billing provider. 33b: Enter qualifier 1D and Medicaid provider number.									

NUCC Instruction Manual available at: www.nucc.org

Section 5 CMS-1500 Example: Effective with NPI Implementation Date (to be announced). Refer to future NPI publications for NPI

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (BLK LUNG) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)																																																																																									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous)										11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED										14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO										19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB <input type="checkbox"/> YES <input type="checkbox"/> NO										21. MEDICAID F CODE										22. PRIOR AUTH									
23. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT I. QUAL J. REFERRING PROVIDER ID #										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT I. QUAL J. REFERRING PROVIDER ID #										25. FEDERAL TAX I.D. NUMBER										26. ACCEPT ASSIGNMENT? (For gov't claims, one tick) YES <input type="checkbox"/> NO <input type="checkbox"/>										27. TOTAL CHARGE \$										28. AMOUNT PAID \$										29. BILLING PROVIDER INFO & PH #																																																	
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										31. SERVICE FACILITY LOCATION INFORMATION										32. BILLING PROVIDER INFO & PH #										33. BILLING PROVIDER INFO & PH #										34. BILLING PROVIDER INFO & PH #										35. BILLING PROVIDER INFO & PH #										36. BILLING PROVIDER INFO & PH #										37. BILLING PROVIDER INFO & PH #										38. BILLING PROVIDER INFO & PH #										39. BILLING PROVIDER INFO & PH #										40. BILLING PROVIDER INFO & PH #									

17a: Enter qualifier 1D and CA override number (if applicable) OR qualifier ZZ and referring provider's taxonomy number. Referring taxonomy code is not required.

17b: NPI for CA PCP for CA authorization or referring provider.

19: No longer used for Carolina ACCESS.

24 I and J: Enter qualifier ZZ and attending taxonomy code.

24J: Attending provider NPI. Required if billing with group NPI.

32: Rendering location address. Must include ZIP + 4 Code.

33: Billing provider information. Must include ZIP + 4 Code.

33a: NPI for billing provider. 33b: Enter qualifier ZZ and taxonomy.

UB-04 Changes Effective March 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at www.nubc.org. Refer to NPI publications for NPI implementation dates. Changes to NC Medicaid programs and policies related to the implementation of the UB04 claim form will be addressed in separate bulletins. Information regarding NC Medicaid filing requirements and billing guidelines can be found at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

- Form locator 1: Name and service facility location (address must include ZIP + 4 Code) of the provider
- Form locator 2: Billing name and address (address must include ZIP + 4 Code) for the payment if different than that of the provider in FL1.
- Form locators 39–41 (Value Codes): Use value codes to identify covered days (80), non-covered days (81), co-insurance days (82) and lifetime days (83). Refer to the UB-04 manual for other value code definitions.
- Form locator 56 (NPI): Billing provider's NPI. Enter the billing provider NPI. N.C. Medicaid requests that providers immediately start submitting the NPI with their Medicaid provider number.
- Form locator 57 (Other Payer ID): Enter the billing provider's Medicaid number on line A, B or C, to correspond with the Medicaid payer name.
- Form locator 76: (Attending provider): Enter the attending provider's NPI in the first space of this form locator, if applicable. Enter the attending provider's Medicaid provider number in the second space with qualifier G2, if applicable.
- Form locator 78 (Other): Enter qualifier DN for Referring Provider in the first space. The NPI of the CA PCP for claims requiring CA authorization or the referring provider may be entered in the second space identified as NPI. Enter either the CA PCP Medicaid provider number for claims requiring CA authorization, referring provider or the CA ACCESS override number assigned by EDS with qualifier G2 in the third and fourth space identified as QUAL field.
- Form locator 81 (Code-Code): Enter qualifier B3 and the billing provider taxonomy code. During transition, taxonomy is not required.

UB-04 Form Change Instructions

Instructions for completing the standard UB-04 claim form as it relates to the claim form field changes are listed below. These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUBC. The NUBC instruction manual can be found at www.nubc.org. Refer to NPI publications for NPI implementation dates. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

Form Locator/Description	Requirements	Explanation
1. Provider Name/Address/ City/State/Zip	Required	Enter the provider's name and the service facility location. The ZIP code must be in the ZIP + 4 format.
2. Pay-to Name/ Address/ City/State/Zip	Required	Enter the provider's name and address (address must include ZIP + 4 Code) for the payment if different than that of the provider in FL1.
39.-41., a-d Value Codes and Amounts	Required, where applicable	80 Covered Days 81 Noncovered Days 82 Co-insurance Days 83 Lifetime Reserve Days NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm .
50. Payer Name	Required	Enter the name of the insurance payer and the two-character payer code. Payer Codes for NC Medicaid is - Medicaid MC
56. NPI	Required	Enter your National Provider Identification number.
57. Other Provider ID	Required	Enter the Medicaid provider number without a qualifier
76. Attending Provider Information	Required, where applicable	Enter the attending provider's NPI or Medicaid provider number and G2 qualifier.

Form Locator/Description	Requirements	Explanation
78. Carolina Access PCP/Referring Provider	Required, where applicable	Enter DN then the NPI for the CA PCP for claims requiring CA authorization or Referring provider if applicable. Enter the CA override or Medicaid provider number for claims requiring CA authorization or Referring provider with G2 qualifier, if applicable.
81. Code –Code Field	Required	Enter qualifier B3 and the Billing provider taxonomy code. During transition, taxonomy is not required.

Note: Quick Reference Guides for Carolina ACCESS Provider on pages 17-21

**Section 6 UB-04 Example Effective March 1,
2007 through NPI Implementation Date (to
be announced).**

1		2		3a PAY CONT.		4 TYPE (IF BILL)	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7			
8		9		10		11	
12		13		14		15	
16		17		18		19	
20		21		22		23	
24		25		26		27	
28		29		30		31	
32		33		34		35	
36		37		38		39	
40		41		42		43	
44		45		46		47	
48		49		50		51	
52		53		54		55	
56		57		58		59	
60		61		62		63	
64		65		66		67	
68		69		70		71	
72		73		74		75	
76		77		78		79	
80		81		82		83	
84		85		86		87	
88		89		90		91	
92		93		94		95	
96		97		98		99	
100		101		102		103	
104		105		106		107	
108		109		110		111	
112		113		114		115	
116		117		118		119	
120		121		122		123	
124		125		126		127	
128		129		130		131	
132		133		134		135	
136		137		138		139	
140		141		142		143	
144		145		146		147	
148		149		150		151	
152		153		154		155	
156		157		158		159	
160		161		162		163	
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168		169		170		171	
172		173		174		175	
176		177		178		179	
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188		189		190		191	
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204		205		206		207	
208		209		210		211	
212		213		214		215	
216		217		218		219	
220		221		222		223	
224		225		226		227	
228		229		230		231	
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240		241		242		243	
244		245		246		247	
248		249		250		251	
252		253		254		255	
256		257		258		259	
260		261		262		263	
264		265		266		267	
268		269		270		271	
272		273		274		275	
276		277		278		279	
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284		285		286		287	
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**Section 7 UB-04 Example: Effective with NPI
Implementation Date (to be announced).
Refer to future NPI publications for NPI**

1										4 TYPE OF BILL									
8 PATIENT										5 FED. TAX NO.									
10 BIRTH										6 STATEMENT COVERS PERIOD FROM THROUGH									
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32 OCCURRENCE DATE										8									
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SECTION 9 INSTRUCTIONS FOR THE 2006 ADA CLAIM FORM

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

ADA Changes Effective March 1, 2007: Revised Claim Transition

- Field 35 (Remarks): Enter the billing provider's taxonomy code.
- Field 48 (Address): Enter the provider address information which must include the ZIP + 4 Code.
- Field 49 (NPI): Enter the billing provider's NPI number.
- Field 52A (Additional Provider ID): Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.
- Field 54 (NPI): Enter the attending provider's NPI number.
- Field 56 (Address): Enter the provider address information which must include the ZIP + 4 Code.
- Field 56A (Provider Specialty Code): Enter the attending provider's taxonomy code.
- Field 58 (Additional Provider ID): Enter the Medicaid attending provider number. After NPI implementation, the Medicaid attending provider number is no longer required and should not be entered on the request.

ADA Claim Form Instruction Changes

Instructions for the 2006 ADA Form as it relates to the claim form field changes are listed below. Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates. . NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

Field Number	Field Name	Explanation
35	Remarks	Enter the billing provider's taxonomy code.
48	Billing Address, City, State, Zip Code	Enter the address, including ZIP + 4 Code.
49	NPI	Enter the billing provider's NPI.
52A	Additional Provider ID	Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.
54	NPI	Enter the attending provider's NPI number for the individual dentist rendering the service. This number should correspond to the signature in field 53.
56	Address, City, State, Zip Code	Enter the address, including ZIP + 4 Code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy code.
58	Additional Provider ID	Enter the Medicaid attending provider number. After NPI implementation, the Medicaid attending provider number is no longer required and should not be entered on the request.

ADA Example Effective March 1, 2007 through NPI Implementation
Date (to be announced).

ADA Dental Claim Form

HEADER INFORMATION																																																																																													
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																													
2. Predetermination/Preauthorization Number																																																																																													
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																																													
3. Company/Plan Name, Address, City, State, Zip Code																																																																																													
OTHER COVERAGE																																																																																													
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																													
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																													
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																																																																																									
9. Plan/Group Number				10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																													
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																																																																																													
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																													
13. Date of Birth (MM/DD/CCYY)				14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)																																																																																							
16. Plan/Group Number				17. Employer Name																																																																																									
PATIENT INFORMATION																																																																																													
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> FTH <input type="checkbox"/> PTS																																																																																													
19. Student Status <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																													
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																													
21. Date of Birth (MM/DD/CCYY)				22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																																																																																							
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24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)		28. Tooth Surface		29. Procedure Code		30. Description		31. Fee																																																																															
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35. Remarks																																																																																													
AUTHORIZATIONS																																																																																													
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist/dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment in connection with this claim.																																																																																													
X Patient/Guardian signature _____ Date _____																																																																																													
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.																																																																																													
X Subscriber signature _____																																																																																													
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or claim on behalf of the patient or insured subscriber)																																																																																													
48. Name, Address, City, State, Zip Code																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">54: Attending NPI.</div>																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">56A: Attending taxonomy.</div>																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">58: Attending Medicaid provider number.</div>																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">49: Billing NPI.</div>																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">52A: Billing Medicaid provider number.</div>																																																																																													
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">48 & 56: Address including ZIP + 4 Code.</div>																																																																																													

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52A: Billing
Medicaid provider
number, for prior
approval purposes
only.

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SECTION 10 QUICK REFERENCE GUIDES FOR CAROLINA ACCESS PROVIDERS

Significant changes regarding the placement of Carolina ACCESS information have occurred on both the CMS-1500 and the UB-04 claim forms. Outlined below are specific timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on the claim. Please make note of these filing requirements.

CMS-1500 (08/05)

Claims Processed with CA PCP Authorization and/or CA Override

Transition Dates: Jan. 1, 2007, until NPI implementation

Effective July 1, 2007, providers must submit on the new CMS-1500 (08/05) claim form. Providers filing on the new CMS-1500 (08/05) claim form must follow the process below for claims received from Jan. 1, 2007, until NPI implementation.				
<i>Block</i>	<i>Block Name</i>	<i>Required Field Yes / No</i>	<i>Value</i>	<i>Explanation</i>
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number.
17a (larger shaded box)	PCP Referral Number or CA Override Number	Yes	Medicaid Provider # or CA Override #	Enter the CA PCP referral number (Medicaid provider number) or the CA override number assigned by EDS.
17b	NPI (National Provider Identifier)	No	NPI Number	The CA referral information is processed from block 17a.

CMS-1500 (08/05)**Claims Processed with CA PCP Authorization****Effective with NPI implementation**

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	No		
17a (larger shaded box)	Taxonomy Number of Referring Provider	No		
17b	NPI	Yes	CA referring provider's NPI number	This is a required field.

Note: If any value is entered in field 17a other than ZZ or blank, the claim will deny. If you enter a ZZ qualifier in field 17a you must enter the taxonomy number in field 17a or the claim will deny.

CMS-1500 (08/05)**Claims Processed with CA Override****Effective with NPI implementation**

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied.
17a (larger shaded box)	CA Override Number	Yes	EDS-issued override number	
17b	NPI	No		Will not have NPI of referring provider.

UB-04**Claims Processed with CA PCP Authorization/Referral or CA Override****Transition Dates: March 1, 2007, through NPI implementation**

Providers filing on the new UB-04 claim form must follow the process below for claims received from March 1 until NPI implementation.				
Form Locator	Description	Required Field Yes / No	Value	Explanation
78 (blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number. If any other value is entered, the claim will be denied.
78 (blank field 4)	PCP Referral Number or CA Override Number	Yes	Medicaid provider # or EDS-issued CA override #	Enter the current CA PCP number (Medicaid provider #) or the CA override number assigned by EDS.
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

UB-04**CA Claims Processed with PCP Authorization/Referral****Effective with NPI implementation**

Form Locator	Description	Required Field Yes / No	Value	Explanation
78 (blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	Yes	CA referring provider's NPI number	This is a required field.
78 (blank field 3)	Qualifier	No		
78 (blank field 4)	Other Provider Identifier of Referring Provider	No		
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

UB-04**CA Claims Processed with CA Override Number****Effective with NPI implementation**

Form Locator	Description	Required Field Yes / No	Value	Explanation
78(blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number. If any other value is entered, the claim will be denied.
78 (blank field 4)	CA Override Number	Yes	EDS-issued override number	
78 (blank field 5) Last	Last Name of Referring Provider	No		.
78 (blank field 6) First	First Name of Referring Provider	No		